# SEMI-ANNUAL REPORT OF CLEAN CLAIM DATA — Due twice each year

**Please either email to mc_filings.mia@maryland.gov or fax to 410-468-2245**

## Clean Claim Data Filing Report

**Note:** *For those fields that are not applicable, enter zero (0).*

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| **1.** | **AA.** | **Today's date (mm/dd/yyyy) as the claims data filing date.** | |
| **2.** | **AB.** | **Full company name of the Payor submitting this report.** | |
| **3.** | **AC.** | **FEIN # [without hyphen (-)] (and NAIC # if applicable) of the Payor submitting this report.** | |
| **4.** | **AD.** | **Select the best description of the Payor submitting this report.** | ○ Insurer (includes all payors except those listed below)<br>○ Health Maintenance Organization (HMO)<br>○ Managed Care Organization (MCO)<br>○ TPA/Delegated Agent (submitting data for another entity)<br>○ Vision Service Plans (VSP)<br>○ Dental Benefit Plan Organizations (DPO)<br>○ Pharmacy Benefit Managers (PBM) |
| **5.** | **AE.** | **What is the report period for this semi-annual claims filing?** | ○ 01/01 - 06/30/_____<br>○ 07/01 - 12/31/_____ |
| **6.** | **AF.** | **Enter the Payor's NAIC Group # if applicable.** | |
| **7.** | **AG.** | **What data elements are required on the CMS Form 1500 and/or Form UB 92 uniform claim forms for the Payor to determine Clean Claims?** | ○ **All of the essential data elements specified by COMAR 31.10.11**<br>○ **Fewer than all of the essential elements specified by COMAR 31.10.11**<br>○ **Not Applicable** |
| | | **Section I** | |
| **8.** | **1A.** | **Enter the number of Clean Claims received (on CMS Form 1500/UB 92 claim forms only and having the required data elements).** | |
| **9.** | **1B.** | **Enter the number of Clean Claims paid (include paid and partially paid claims). Enter "0" if no paid claims reportable.** | |
| **10.** | **1C.** | **Enter the number of the received claims that were denied because CMS Form 1500 UB 92 data were incomplete or missing. Enter "0" if no** | |

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| | | **denied claims reportable.** | |
| **11.** | **1D.** | **Enter the number of received claims that were denied because an attachment to the corresponding CMS Form 1500 or UB 92 was incomplete or missing. Enter "0" if no denied claims reportable.** | |
| | | **Section II** | |
| **12.** | **2A.** | **Enter the total number of adjudicated claims received for this period. (Note: 2A must = 2B + 2C)** | |
| **13.** | **2B.** | **Enter the number of adjudicated claims paid (includes paid and partially paid claims).** | |
| **14.** | **2C.** | **Enter the number of adjudicated claims denied payment for the report period.** | |
| **15.** | **2D.1.** | **From the following list, identify the best description of the most prevalent reason (explanation) for the denial of claim payment. Enter "NOT APPLICABLE" if no denied claims for report period.** | ACCIDENT<br>ADDITIONAL<br>AUTHORIZATION<br>BILL<br>COB<br>DUPLICATE<br>EOB<br>INELIGIBLE<br>MAXIMUM<br>MEDICARE<br>MISCELLANEOUS<br>NOT APPLICABLE<br>NONCOVERED<br>PREEXISTING<br>PROVIDER<br>TERMINATED<br>UCR<br>UNTIMELY<br>**NOTE:** For further clarification, please see manual. |
| **16.** | **2D.1.1** | **Enter the number of claims denied for the most prevalent reason for denial. Enter "0" if no denied claims reportable.** | |

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| **17.** | **2D.2.** | **From the following list, identify the best description of the second most prevalent reason (explanation) for the denial of claim payment. Enter "NOT APPLICABLE" if no denied claims for the report period.** | ○ ACCIDENT<br>○ ADDITIONAL<br>○ AUTHORIZATION<br>○ BILL<br>○ COB<br>○ DUPLICATE<br>○ EOB<br>○ INELIGIBLE<br>○ MAXIMUM<br>○ MEDICARE<br>○ MISCELLANEOUS<br>○ NOT APPLICABLE<br>○ NONCOVERED<br>○ PREEXISTING<br>○ PROVIDER<br>○ TERMINATED<br>○ UCR<br>○ UNTIMELY<br>**NOTE:** For further clarification, please see manual. |
| **18.** | **2D.2.1** | **Enter the number of claims denied for the second most prevalent reason for denial. Enter "0" if no denied claims reportable.** | ☐ |
| **19.** | **2D.3.** | **From the following list, identify the best description of the third most prevalent reason (explanation) for the denial of claim payment. Enter "NOT APPLICABLE" if no denied claims for the report period.** | ○ ACCIDENT<br>○ ADDITIONAL<br>○ AUTHORIZATION<br>○ BILL<br>○ COB<br>○ DUPLICATE<br>○ EOB<br>○ INELIGIBLE<br>○ MAXIMUM<br>○ MEDICARE |

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| | | | ○ MISCELLANEOUS<br>○ NOT APPLICABLE<br>○ NONCOVERED<br>○ PREEXISTING<br>○ PROVIDER<br>○ TERMINATED<br>○ UCR<br>○ UNTIMELY<br>**NOTE:** For further clarification, please see manual. |
| **20.** | **2D.3.1** | **Enter the number of claims denied for the third most prevalent reason for denial. Enter "0" if no denied clams reportable.** | |
| **21.** | **2D.4.** | **From the following list, identify the best description of the fourth most prevalent reason (explanation) for the denial of claim payment. Enter "NOT APPLICABLE" if no denied claims for the report period.** | ○ ACCIDENT<br>○ ADDITIONAL<br>○ AUTHORIZATION<br>○ BILL<br>○ COB<br>○ DUPLICATE<br>○ EOB<br>○ INELIGIBLE<br>○ MAXIMUM<br>○ MEDICARE<br>○ MISCELLANEOUS<br>○ NOT APPLICABLE<br>○ NONCOVERED<br>○ PREEXISTING<br>○ PROVIDER<br>○ TERMINATED<br>○ UCR<br>○ UNTIMELY<br>**NOTE:** For further clarification, please see manual. |
| **22.** | **2D.4.1** | **Enter the number of claims denied for the fourth most prevalent reason for** | |

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| | | **denial. Enter "0" if no denied clams reportable.** | |
| **23.** | **2D.5.** | **From the following list, identify the best description of the fifth most prevalent reason (explanation) for the denial of claim payment. Enter "NOT APPLICABLE" if no denied claims for the report period.** | ○ ACCIDENT<br>○ ADDITIONAL<br>○ AUTHORIZATION<br>○ BILL<br>○ COB<br>○ DUPLICATE<br>○ EOB<br>○ INELIGIBLE<br>○ MAXIMUM<br>○ MEDICARE<br>○ MISCELLANEOUS<br>○ NOT APPLICABLE<br>○ NONCOVERED<br>○ PREEXISTING<br>○ PROVIDER<br>○ TERMINATED<br>○ UCR<br>○ UNTIMELY<br>**NOTE:** For further clarification, please see manual. |
| **24.** | **2D.5.1** | **Enter the number of claims denied for the fifth most prevalent reason for denial. Enter "0" if no denied clams reportable.** | |
| | | **Section III** | |
| **25.** | **3A.** | **Enter the beginning claim processing inventory (i.e., the number of unprocessed plus pending claims at the start of the report period). This number should correspond to the ending inventory of the previous report period.** | |
| **26.** | **3B.** | **Enter the number of claims pending for legitimate dispute or for additional information at the end of this report period. Enter "0" if there are no pending claims.** | |
| **27.** | **3C.** | **Enter the number of claims received for adjudication during the report period, but are as yet unprocessed.** | |

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| | | **Unprocessed claims have not yet been paid, denied or pended. Enter "0" if there are no unprocessed claims.** | |
| **28.** | **3D.** | **Enter the ending claim processing inventory (i.e., unprocessed plus pended claims) at the end of the report period. (Note: 3D = 3B + 3C)** | |
| **Section IV** | | | |
| **29.** | **4A.** | **Enter the total number of all claims paid, partially paid and denied for the report period. All claims processed includes claims received during the report period and previously unprocessed claims. (Note: 4A = 4B.1 + 4C.1 + 4D.1)** | |
| **30.** | **4B.1.** | **Enter the number of all claims processed in thirty (30) calendar days or less for this report period.** | |
| **31.** | **4B.2.** | **Enter the dollar amount of benefits paid or partially paid for claims processed in thirty (30) calendar days or less for this report period.** | $ |
| **32.** | **4B.3.** | **Enter the dollar amount of interest paid on any claims processed in thirty (30) calendar days or less for this report period.** | $ |
| **33.** | **4C.1.** | **Enter the number of all claims processed in 31 to 60 calendar days for this report period. Enter "0" if no paid claims reportable.** | |
| **34.** | **4C.2.** | **Enter the dollar amount of benefits paid or partially paid for claims processed in 31 to 60 calendar days for this report period. Enter "0" if no paid claims reportable.** | $ |
| **35.** | **4C.3.** | **Enter the dollar amount of interest paid on any claims processed in 31 to 60 calendar days for this report period. Enter "0" if no paid interest reportable.** | $ |
| **36.** | **4D.1.** | **Enter the number of all claims processed in 61 or more calendar days for this report period. Enter "0" if no paid claims reportable.** | |
| **37.** | **4D.2.** | **Enter the dollar amount of benefits paid or partially paid for claims processed in 61 or more calendar days for this report period. Enter "0" if no paid claims reportable.** | $ |
| **38.** | **4D.3.** | **Enter the dollar amount of interest paid on any claims processed in 61 or more calendar days for this report period. Enter "0" if no paid interest reportable.** | $ |
| **Section V** | | | |

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| 39. | 5A. | Enter the name of the company that this report is about. If you are a delegated agent processing claims on behalf of another entity, enter the full name of the delegating entity. Otherwise, enter your company name. | |
| 40. | 5B. | Enter the NAIC number (FEIN number if NAIC does not exist) for the company that this report is about. Enter NAIC Group number if exists. | NAIC #: NAIC Group #: FEIN #: |
| 41. | 5C. | If the Payor filing this report is a delegated agent processing claims on behalf of another entity, indicate whether the Payor has previously submitted Clean Claim reports for the delegating entity. | Yes No |
| 42. | 5E. | Enter the street address for the Payor submitting this report. | |
| 43. | 5F. | Enter the city of the Payor submitting this report. | |
| 44. | 5G. | Select the state of the Payor submitting this report. | |
| 45. | 5H. | Enter the Zip Code or Postal Code of the Payor submitting this report (e.g., xxxxx, xxxxx-xxxx). | |
| 46. | 5I. | Enter the contact person name for the Payor submitting this report. | |
| 47. | 5J. | Enter the Payor contact person telephone number (xxx-xxx-xxxx). | |
| 48. | 5K. | Enter the Payor contact person e-mail address (e.g., john.doe@email.com). | |
| | | **Section VI** | |
| 49. | 6A. | Optional - enter any brief explanatory comments (250 characters) concerning the completion and filing of this report. | |

You have successfully completed the form and are now ready to submit it to the Insurance Commissioner. By submitting this report you hereby certify on behalf of the Payor that all information provided is complete, true, and correct to the best of your knowledge and belief in accordance with Maryland laws and regulations.